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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

THE DIALOGUE DISCUSSION BOARD IS CHANGING

Starting with the Summer 2006 issue, *The Dialogue* Discussion Board will change to a new feature called Ask the Field. In each issue, SAMHSA DTAC staff will identify an emerging issue in disaster behavioral health and ask a field professional to give their perspective on that issue.

DISCUSSION BOARD

Our last discussion topic: As numerous shelters were set up to house and assist evacuees from the 2005 hurricanes, what were the challenges and lessons learned in providing behavioral health services to individuals and families in such settings?

Response: While touring numerous shelters from New Orleans to Pearlington, MS, during early deployments to the region, I noticed that while the provision of food, water, and temporary shelter was evident, behavioral health services lagged behind. The uncertainty of the next day's events was evident in the eyes and faces of children, adolescents, and adults. The disturbing images and memories, triggered by constant exposure to the aftermath of the storm, no doubt led to increasing levels of distress. The need for mental health services was huge. One of the greatest challenges was providing immediate services to those most in need. This was visibly apparent upon entering the River Center in Baton Rouge, LA, where an African-American volunteer cried out, "Thank God you are here!" The difficulty in collaborating with various agencies created challenges ranging from availability of culturally competent professionals to the actual implementation of immediate and ongoing, empirically sound, culturally sensitive interventions.

Russell T. Jones, Ph.D., professor of psychology, Virginia Tech University.

SAMHSA's Response to the 2005 Hurricanes

As the aftermath of the 2005 hurricanes continues to create behavioral health needs in the gulf coast States and across the country, SAMHSA remains focused on providing resources, guidance, and support to aid in the recovery process. As of April 2006, the following efforts have been made:

>> SAMHSA has mobilized more than 800 mental health and substance abuse professionals to provide services to hurricane survivors.

>> SAMHSA's Center for Mental Health Services is providing grant support and technical assistance to FEMA's Crisis Counseling Assistance and Training Program.

>> The SAMHSA Suicide Prevention Hotline, 1-800-273-TALK, remains available as a resource for hurricane survivors and their care providers.

>> SAMHSA continues to provide information and guidance:

- Disaster behavioral health and hurricane resources at http://www.mentalhealth.samhsa.gov/disasterrelief;
- Public service announcements at http://www.mentalhealth.samhsa.gov/disasterrelief/psa.aspx;
- Disaster behavioral health Webcasts at http://www.mentalhealth.samhsa.gov/disasterrelief/pubs/responder.asp; and
- Disaster technical assistance at www.mentalhealth.samhsa.gov/dtac.

CSAT Disaster Recovery Resources CD-ROM

SAMHSA's Center for Substance Abuse Treatment (CSAT) has released a CD-ROM containing disaster-related substance abuse resources targeted to substance abuse and disaster behavioral health professionals.

Featured reports: *A Report on the Post-September 11 State Disaster Relief Grant Program of SAMHSA's Center for Substance Abuse Treatment* and *Traumatic Events and Substance Use Demands on the Substance Abuse Treatment Delivery System.*

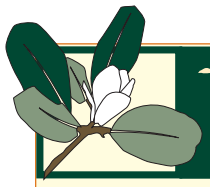
Outreach resources: Fact sheets from the National Center for Post-Traumatic Stress Disorder on disasters and substance abuse/dependence and alcohol use; guides for parents and teachers, older adults, and teens that include common reactions and responses to disaster and trauma; and self-care tips for dealing with stress and the special needs of emergency and disaster response workers.

Preparedness resources: An emergency preparedness plan; all-hazards response planning for State substance abuse service systems; and the FEMA Continuity of Operations Plan template.

Lessons learned resources: *New York State Office of Alcoholism and Substance Abuse Services (OASAS) Response to the September 11, 2001, Terrorist Attack on the World Trade Center Towers in New York City; The Impact of 9/11 on New York City's Substance Abuse Treatment Programs: A Study of Patients and Administrators;* and *Substance Abuse Treatment Implications to Terrorism Events.*

The CD also includes links to bibliographies of resources on issues related to the treatment of substance abuse and posttraumatic stress disorder in the general population, women, adolescents, ethnic groups, and first responders.

To order this CD, contact the SAMHSA National Clearinghouse for Alcohol and Drug Information at http://www.health.org, and follow the "Quick Find and Order" link.



The Spirit of Recovery

The Spirit of Recovery: All-Hazards Behavioral Health Preparedness and Response–Building on the Lessons of Hurricanes Katrina, Rita, and Wilma

May 22–24, 2006
New Orleans

OVERVIEW AND PURPOSE

During the past year, the United States has experienced an unprecedented number of disasters, including the hurricanes that devastated the gulf coast region, school shootings, and suicide clusters. SAMHSA continues to emphasize the importance of all-hazards disaster behavioral health preparedness. SAMHSA is convening a national summit as a followup to previously held trainings to work with States, Territories, and the District of Columbia through the planning process. This meeting will allow States and Territories to assess the progress made on disaster behavioral health plans and to help address existing barriers and needs. Participants will interact in a peer-to-peer environment to do the following:

>> Review lessons learned from Hurricanes Katrina, Rita, and Wilma.

>> Identify opportunities for consolidation of the ongoing response to behavioral health issues resulting from the 2005 hurricanes.

>> Strategize all-hazards preparedness efforts for future disasters.

TOPICS TO BE ADDRESSED

The event will be structured to promote intensive analysis and knowledge sharing and will include presentations and workshops. Topics may include the following:

>> Substance use and mental health treatment.

>> Populations with special considerations.

>> Evacuation and displacement.

>> Emergency response centers.

>> Research and clinical experience.

>> Partnerships and coalition building.

>> Public safety workers.

>> Disaster-related suicide.

>> Methadone treatment.

>> Regional collaboration.

ATTENDANCE

Each State and Territory has been invited to form a 10-person team consisting of mental health and substance abuse commissioners, disaster behavioral health coordinators, health department disaster coordinators, emergency management disaster coordinators, and other key partners (e.g., voluntary agency leads, faith-based organizations, consumer/survivor representatives, community associations). Stakeholders from associations and Federal partners also have been invited in order to establish a setting conducive to collaboration on all levels.

For more information, go to **http://www.spiritofrecoverysummit.com.**

Mental Health Response to Hurricane Katrina in Tulsa, OK

On December 6, 2005, under the auspices of the University of Tulsa's (TU) and the Tulsa Community Service Council's Center for Community Research and Development (CCRD), several community stakeholders assembled to discuss the lessons learned from the Tulsa/Muskogee mental health response to the Hurricane Katrina evacuees in that part of Oklahoma. This summary explains the behavioral health response efforts of local organizations and lessons learned along the way.

Tulsa, OK, has a long tradition of community collaboration in disaster preparedness. The community history of responding to floods, tornadoes, and other events has propelled Tulsa agencies and organizations to become active planners and collaborators. In addition, mental health professionals have learned many lessons from the bombing of the Alfred P. Murrah Federal Building in Oklahoma City in 1995 and from an extremely destructive F-5 tornado in 1999.

For many years, the Tulsa Human Response Coalition, with members from Family and Children's Services of Tulsa, the Tulsa Community Service Council, the Tulsa Mental Health Association, TU, the American Red Cross (ARC), faith-based professionals, and private practitioners, has been hosting mock exercises for the community, encouraging training in disaster response, exploring issues of tension between science and practice in disaster response, and devising a credentialing system for mental health responders.

At the time Hurricane Katrina hit, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), through a SAMHSA-funded All-Hazards Behavioral Health Capacity Building Grant, had trained many State professionals about the psychological consequences of disasters and terrorism. In addition, the Oklahoma State University Area Health Education Center completed a grant funded by the Health Resources and Services Administration that trained physicians and first responders in bioterrorism preparedness for rural areas, which included a mental health component. Oklahoma also had three SAMHSA-funded National Child Traumatic Stress Network (NCTSN) sites, which worked individually and collectively on improving children's trauma-related services. Because of this preparation, at the beginning of fall 2005, the greater Tulsa community had a breadth and depth of awareness, training, experience, commitment, and expertise in disaster mental health for adults and children.

HURRICANE KATRINA RESPONSE

Mental health professionals responded to Hurricane Katrina in three primary ways. First, Thursday, September 1, 2005, 3 days after Katrina hit the gulf coast, the Tulsa community recognized the need to organize a mental health response for evacuees who relocated to the area. University of Oklahoma (OU) primary care physicians who worked at the Bedlam Community Health Partnership (a public health clinic) began to assess and treat Hurricane evacuees who arrived in Tulsa on their own. OU contacted Family and Children's Services of Tulsa (FCS) who agreed to provide mental health support. Thereafter, FCS and TU psychology faculty and students collaborated to coordinate and provide mental health support to the Bedlam clinic physicians who were working at the ARC clinic, which was housed at a community church.

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This mental health response lasted for a total of 30 days and consisted of providing a sense of safety and comfort, stabilizing the few emotionally overwhelmed survivors, identifying and addressing current needs and concerns, offering practical assistance, facilitating connections with social support systems, and providing information on coping and fostering resiliency.

In addition, mental health staff encouraged physicians and ARC staff to take necessary breaks, and assisted those who became overwhelmed by some of the evacuees' distress. For those with chronic mental health problems, the interventions of choice were contact with local services, education about Tulsa's 24-hour mental health crisis team (FCS COPES Team), and use of the crisis team for wellness checks. When not serving clients, the mental health teams provided physicians with any practical support they needed.

Second, Tulsa mental health professionals helped staff the needs of Camp Gruber, located in Braggs, OK, in Muskogee County, a site currently used for National Guard training and a former World War II prisoner of war camp. Camp Gruber, which is approximately 60 miles from Tulsa, is located in a rural area far from public transportation services. For the first 2 days, the ARC Mental Health Disaster Response Team initiated and organized the mental health response, which involved triage and identification of needs.

Due to the much-higher-than-anticipated acuteness and chronicity of both health and mental health needs of the evacuees, the Commissioner of Health requested that ODMHSAS provide additional professional mental health coverage for the camp. In addition to provision of a psychiatrist and nursing personnel to address these needs, ODMHSAS requested Green Country Behavioral Health Services, the local community mental health provider, to take the lead in organizing mental health services for the camp. Green Country focused mainly on the needs of people with chronic mental illnesses and people with substance use issues, and onsite supervision of all behavioral and mental health volunteers.

Other entities supported additional mental health needs using teams of two to establish a presence around the camp, talk to evacuees, and identify and intervene if an individual was in

significant distress. Officially, through their Crisis Team and the SAMHSA-funded NCTSN Type III center, Oklahoma Child Traumatic Stress Treatment Collaborative, FCS coordinated and scheduled services from additional mental health workers and volunteers. Camp Gruber operated until October 6, 2005.

Third, providers in the community offered free training in the SAMHSA-funded psychological first aid developed by the National Center for Post-Traumatic Stress Disorder and the National Center for Child Traumatic Stress. Additional providers offered at-cost training in other immediate response models.

Although statistics vary by source, the numbers appear to be relatively consistent. The ARC Tulsa Area Chapter reports that 2,150 hurricane cases were opened, including the 1,476 evacuees at Camp Gruber. According to FEMA, Tulsa was ranked 62nd out of 370 reported locations within U.S. Census Metropolitan Statistical Areas, with 1,365 evacuees.

LESSONS LEARNED

Overall, we accomplished a great deal as a community and were able to provide much-needed care. We all agreed that the most important value was "Do no harm." The generosity of our community agencies in providing time for

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mental health volunteers to work, providing free trainings, and donating supplies was inspirational. In addition, we were impressed with the overall flexibility of individuals and entities in responding to needs. Although it was challenging, we were encouraged by the collaborative spirit of our providers and the relationship between mental health experts and other first responders. We believe that our experiences speak to the talents in our community. However, we also identified new areas we need to consider in the future and gained new insights. The lessons learned include the following:

>> Despite our community expertise and practice in emergency response, no response is perfectly smooth, and the nature of disaster response involves bumps in the road. It does not mean a community is unprepared, but that communication, ongoing assessment of needs, and flexibility are essential.

>> Communication and fragmentation are always issues in a disaster. We both excelled and had problems in this area. This is an area of continued focus.

>> We recognize that our informal, close community collaborations facilitated our disaster response effectiveness. It is vital to continue to work toward helping local communities enhance their disaster preparedness. Strengthening all ongoing system collaborative efforts related to mental health, education, and health services as part of emergency preparedness will enhance local emergency response effectiveness. Coordinating Federal, State, and local responses in ways that place community agencies as leaders in crises needs to be a continued area of focus.

>> The model that worked well for us in Tulsa was having one mental health agency take responsibility for recruiting and scheduling mental health workers so that the other agencies onsite could focus on providing and supervising direct care. This division of duties allowed for enhanced quality of care for evacuees.

>> Although we worked hard to utilize trained disaster responders and to pair experienced with less-experienced providers, complex emergencies require taking advantage of a range of volunteers. Occasionally qualified mental health professionals who engage in therapeutic practices that are not part of the designated emergency response may slip through (e.g., grief counselors and "debriefers" who may approach survivors too early in the process, expecting to do intense psychotherapy). Determining effective ways to screen, supervise, and monitor volunteers in an emergency situation is a challenge that we need to consider more carefully in planning responses.

>> Balancing the need to provide mental health support while fostering evacuees' sense of control and autonomy can be difficult. Further training of mental health workers about subtle and overt methods of appropriately empowering survivors is an area of future development.

>> For sustained response, community agencies need to be aware of financial constraints and include in their planning efforts the consideration of ways services could be billable and ways to respond without neglecting pre-existing mental health needs in the community.

>> We need to learn and conduct more training in culturally competent disaster management. In several instances, cultural beliefs were mistaken for psychosis during initial screening.

>> Our response involved both urban and rural locations that lacked an efficient public transportation infrastructure. This posed problems for some in accessing services. Disaster response planning needs to consider such transportation and safety issues in greater detail. Overall, the system worked best when services were brought to the evacuees onsite, but this is not always possible.

>> A significant difference of opinion was evident regarding the appropriate shift length for mental health workers. This is an area we need to continue to both research and explore with ARC and other entities to create healthy, competent workers and effective services.

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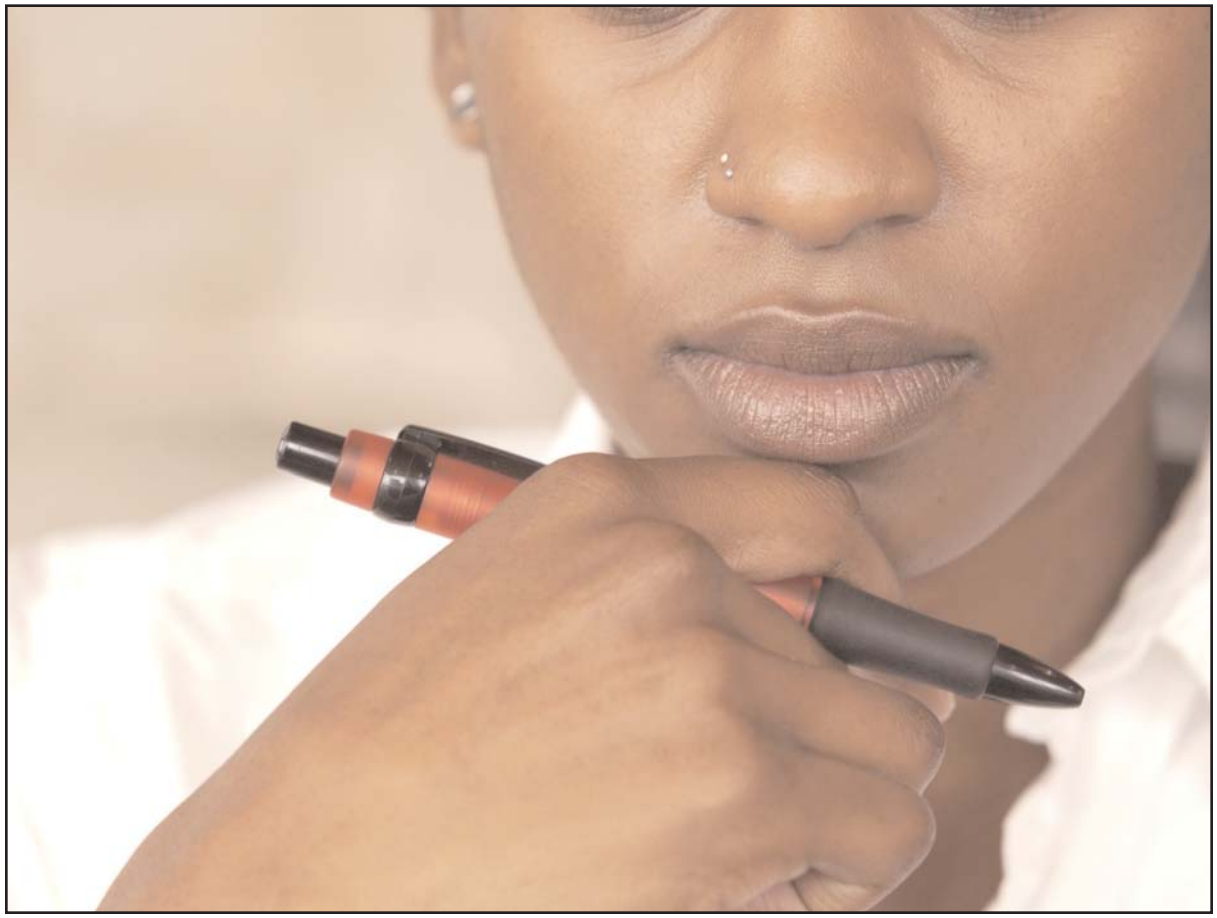
>> Applying mental health principles to mass disaster involves creative use of assessment and problem solving with respect to issues such as safety, crowd management, and minimization of iatrogenic distress. Behavioral health volunteers identified and anticipated issues at Camp Gruber and helped other entities plan their responses. More cross-systems analysis, discussion, and preparation about how to maximize success, reduce inefficiency, and avoid overstepping one's designated area of expertise are areas of future discussion in our community.

>> Although the majority of people we served were caring, law-abiding individuals, anticipating the need to identify and shelter the few gang members and registered sexual offenders in a forced evacuation is essential, especially when unaccompanied children are present. We did well, thanks to the expertise of city gang task forces and justice division representatives, but this was an unanticipated need that further complicated issues. In a camp or shelter setting, this issue also becomes a significant concern for volunteers.

>> For families with a history of, or potential for, domestic violence, mental health professionals need to balance respect for family connections in times of stress with danger assessment and safety planning. More training is needed for staff who do not have domestic violence expertise on how best to manage these situations.

For more information, go to the Center for Community Research and Development's Web site at http://www.cas.utulsa.edu/ccrd.

This article was contributed by Elana Newman, Ph.D., associate professor of psychology, University of Tulsa; and Joanne Davis, Ph.D., associate professor of psychology, University of Tulsa.



Utah Reaching Out: Utah's Crisis Counseling Program for Hurricane Katrina Evacuees

August 29, 2005, Hurricane Katrina slammed into the gulf coast and caused horrific damage in Louisiana, Mississippi, and Alabama, killing 1,422 people. As a result of the devastation, as many as 100,000 people were stranded for nearly a week, homeless, many without food and water, and separated from their families, pets, and friends. In order to help the survivors involved in the wake of the destruction, FEMA implemented a rescue attempt to evacuate survivors of the storm to neighboring States. As part of this effort, approximately 600 African-Americans, most of whom are Baptists, were sent to Salt Lake City, UT, during Labor Day weekend and were welcomed by a State that is overwhelmingly white, Mormon, and conservative.

One of the many challenges the evacuees confronted in Utah was the difference in culture. The differences were emotionally challenging for the many individuals and families who had just survived a chaotic and devastating event. However, most evacuees reported they were glad to be in Utah. One evacuee said, "Swimming and walking in water, in 12 feet of water, I mean you have to hold onto anything that floats to get to dry land. Once you get to dry land, you don't come off. It seems like the end of the world in New Orleans; it's darkness."

It was also clear that even though most were relieved to be out of New Orleans, some evacuees were unhappy with their destination, believing that they were going to Texas.

One of the many challenges the evacuees confronted in Utah was the difference in culture.

In providing crisis counseling during these difficult times, Utah has been successful due to previous planning efforts for effective response developed through the SAMHSA and FEMA Crisis Counseling Assistance and Training Program (CCP). Although this is a fairly small response effort compared to other States' CCPs, there are some significant issues Utah can share that might benefit CCPs nationwide.

The Utah Division of Substance Abuse and Mental Health (DSAMH) started working to provide a coordinated statewide crisis response through efforts with the U.S. Department of Health and Human Services (HHS) by obtaining funding through a bioterrorism grant. The project focused on disaster preparedness and began training crisis counselors for emergencies and disaster events after 9/11 and in preparation for the 2002 Winter Olympics.

Since then, DSAMH has trained crisis counselors annually and has developed a cadre of approximately 450 crisis counselors trained for disaster response statewide. While the training includes an intensive curriculum, with input from SAMHSA's Center Mental Health Services (CMHS), the National Center for Post-Traumatic Stress Disorder, SAMHSA DTAC, the American Red Cross (ARC), Disaster Psychiatry Outreach, the Utah Hospital Association, and other State and local experts. The training does not have licensure requirements for the basic level, it does offer continuing education credits and a certification from the Utah Department of Human Services. This certification provides picture identification and allows crisis counselors to access disaster sites.

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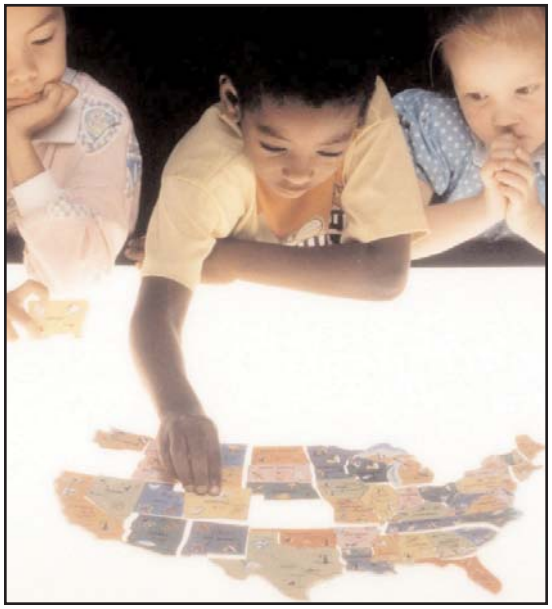
Part of this extensive process was the development of partnerships with several State and local agencies in order to build collaboration and develop an infrastructure for use in the event of an emergency or disaster. This collaboration includes the local Community Mental Health Centers, faith-based and volunteer organizations, nonprofit and for-profit agencies, and various staff members from HHS. Since developing these partnerships, the Utah Department of Public Safety, the U.S. Department of Homeland Security, Police, Fire, and other significant agencies also recognize this identification. This preparation proved to be a critical factor in providing an effective response when the evacuees first came to Utah.



Under the direction of the Utah Department of Human Services, DSAMH managed the crisis counseling response efforts. When plane after plane of evacuees came to Salt Lake City, the National Guard and crisis counselors, along with State officials, faith-based agencies, and ARC, were able to provide an effective response. The evacuees were met with many charitable outreach efforts and were then housed at the Utah National Guard Camp Williams Military Reservation. Crisis counselors worked closely with evacuees to help them adjust to Utah's weather and cope with their multiple losses in a new area far from family and friends.

When Camp Williams closed September 27, 2005, approximately 450 evacuees decided to stay in Utah and were relocated in Salt Lake County and outlying cities throughout the State. The evacuees are clustered in areas being served by the outreach team "Utah Reaching Out."

Since then, additional needs have been identified. According to Dorrinea, an outreach worker, "The people are in culture shock; they are used to living in predominately black neighborhoods." In addition to very practical needs related to training, employment, and getting around in the city, there are concerns about excessive alcohol use, as well as feelings of isolation. One crisis counselor reports that "A lot of them have not yet come to grips with this."

Effective crisis counseling efforts focus on building resilience, and that resilience is evident in many of the evacuees. Utah Reaching Out is working with the evacuees, using a strength-based approach that focuses on helping them meet their own needs and adjust to living in the community. The major needs of evacuees, in addition to the stress of relocation, include acculturation, adjusting to Utah's weather, and coping with multiple losses in a new area far away from family and friends. There has been strong community support for the evacuees. However, that support is likely to fade over time. Thus, it is important that outreach and crisis counseling are available to assist evacuees with this major adjustment.

Utah has an estimated 200 additional spontaneous evacuees in the State. They may be living in temporary shelters or with friends and family members. The emotional toll that the situation has taken on the evacuees continues to evolve, beyond "normal" disaster response and recovery. The process is likely to become a long-term event as the evacuees progress through the phases of recovery.

DSAMH, as the State Mental Health Authority (SMHA), will direct Utah Reaching Out and continue to support evacuees and provide emotional support. The SMHA aims to make this a useful program for those evacuees most in need

continued

of services. It seeks to be cost-effective, with approximately six crisis counseling staff to directly serve an estimated 450 to 600 evacuees during the next 9 months of the Regular Services Program (RSP). In response to serving the evacuees, Utah has been active in working with CMHS and FEMA, and wrote and received an initial grant of $103,804 to provide immediate services and a second grant award of $244,500 to provide continued services under the RSP.

To address some of the cultural adjustment issues, Utah Reaching Out has been working with Baptist Pastor France Davis. Pastor Davis has more than 30 years of experience in Utah working with the African-American community. He has led the efforts with his Calvary Baptist Church to provide services to the CCP. Now more than 450 Katrina survivors, many of them African-American, are calling Utah their home.

Losses include cultural and social networks, family employment, and their faith-based communities. A large percentage have behavioral health needs, and a number of evacuees are growing frustrated and angry about what they perceive as ongoing poor response from the Federal Government. Under the direction of DSAMH, the Calvary Baptist Church will be responsible for the outreach. Pastor Davis will lead the team. This outreach team has vast experience in working with the community and has developed extensive ties throughout Utah. DSAMH will work closely with the team to provide crisis counseling and help with the significant adjustments. Outreach target populations include families, individuals and children. The outreach team will deliver services to the homes of evacuees.

The State has also established a statewide 24-7 crisis hotline for evacuees. The outreach team will provide individual and group counseling, as well as assistance to evacuees as they organize support groups in their own communities. The outreach team will also work to identify behavioral health needs. The team has access to local resources, and licensed mental health professionals will be available for consultation and referral to local entities.

Education and information will be provided to normalize reactions and facilitate coping as the evacuees prepare to live in Utah and as the local communities prepare for their arrival. The content of education and information materials includes common reactions and phases of disaster events. Special attention will be paid to families with children, school systems, and faith-based communities. Crisis counselors will also promote resilience and act as a bridge to other behavioral health supports, as needed.

Analysis of the Immediate Services Program (ISP) data includes several important issues and trends in the physical, emotional, cognitive, and behavioral reactions of evacuees. During the ISP, a particular concern with evacuees was a high incidence of behavioral reactions, with 100 evacuees reporting apathy, decreased energy levels, isolation, and withdrawal; and outreach workers reporting changes in activity level and having difficulty sleeping. A high incidence of emotional reactions was also documented with 170 evacuees reporting feelings of despair and hopelessness, and physical reactions, including a significant incidence of injuries as a result of the event, limited mobility, and loss of independence. Crisis counselors have assessed these reactions, as well as significant loss and relocation, and the issue of cultural differences.

The outreach team also reported a concern regarding the emerging trend of evacuees who are increasing their intake of alcohol or drugs. Crisis counselors report most evacuees are still dealing with their basic needs. Therefore, they are slow in dealing with their emotional responses to the trauma of the disaster.

Group crisis counseling has not been as effective as the individual outreach efforts due to the dispersion of many of the evacuees to outlying cities. As noted, a trend of evacuees feeling isolated and hopeless is particularly disturbing

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and calls for ongoing outreach efforts. The outreach team is working with community agencies and faith-based organizations to offer evacuees additional support, which will be strengthened with ongoing outreach and collaborative efforts to build community alliances.

Ernest, an outreach worker with Utah Reaching Out, reports that some evacuees have experienced trauma and "memories and nightmares about the hurricane, seeing dead bodies, dreams of being trapped under water, and children crying for food." According to other outreach workers, many evacuees have difficulty voicing their concerns and report that their culture discourages sharing behavioral and emotional reactions openly. Often, they only share this information with a clergy member. It is evident with the evacuees now living in Utah that the need for ongoing outreach is critical and that building community support is a gradual process. Some evacuees have been referred to local community mental health centers for medication management, case management, and psychiatric needs, and to other agencies for support of alcohol and substance abuse issues.

In providing crisis counseling, preparation is critical in order to have an effective response. DSAMH values the opportunity to work with and prepare the local communities for disaster events and is now planning to work with the local counties in preparing a disaster plan that includes crisis counseling for special populations. There are also plans to partner closely with the local health departments, schools, higher education institutions, private and non-profit organizations, and homeless shelters to define an extended crisis counseling response in the event of an emergency or disaster event.

This article was contributed by Robert H. Snarr, M.P.A., SSW, CPCI, adult programs manager and project director for the Utah CCP ISP and RSP, Utah Division of Substance Abuse and Mental Health.

NAADAC, The Association for Addiction Professionals' 2005 Hurricane Response

The following interview was conducted by Brian McKernan, M.Ed., ACADC, SAMHSA DTAC, with NAADAC Executive Director Cynthia Moreno Tuohy, NCAC II, CCDC III, and NAADAC Deputy Director Shirley Beckett Mikell, NCAC II, March 8, 2006, at the NAADAC offices in Alexandria, VA.

SAMHSA DTAC: Having organized a deployment of addiction professionals, NAADAC had an active role in the 2005 hurricane response. What was their mission, and can you give us a sense of the scope of the deployment?

Shirley Beckett Mikell (SBM): We were invited to participate in this project by SAMHSA. We got the call late on a Tuesday afternoon, and we needed to make a quick decision to go forward in a short period of time to pull together our addiction professionals and determine if they were willing and eligible to go. We took on the mission because we had personally seen the devastation and had talked to people who had been involved in offering crisis counseling in New Orleans. We had also talked to people in Alabama who had extreme concerns about not having counseling available. I had received a call about people on opiate replacement therapy and the fact that brown heroin was coming into New Orleans. People who had been in recovery for more than 3 years on methadone had been resorting to heroin. So our thought in partnering with SAMHSA was that if other counselors, physicians, psychologists, and nurses were there, at least those people needing methadone and addiction treatment during the confusion could get help. We have a pool of more than 13,000 people certified within NAADAC from which we could pull nationwide and abroad. Ironically enough, we had our open house for Addictions Counselor Day the same day we got the call, September 20. That's how we communicated the information to our counselors, "This is your day. This is an opportunity to give back even more." And they really did respond to the call. We ended up with 235 who applied as volunteers, and there were about 128 who finally became eligible.

Cynthia Moreno Tuohy (CMT): Earlier we had been on several calls with SAMHSA, and they said they were going to send mental health workers. And I said, "Why just mental health workers? There is going to be a huge problem with alcohol and other drugs. Addiction professionals need to be there." It was very encouraging to me to see SAMHSA's response to that information, and to quickly come to us and say "Okay, we need your support in gathering up addiction professionals." Because we are the world's largest group of addiction professionals, they knew they could count on us.

SAMHSA DTAC: You mentioned that the call came in on Addictions Counselor Day. Can you tell us a little more about that?

SBM: We started Addictions Counselor Day 3 years ago as a recognition of addictions counselors. We held an open house with community organizations and some of our own counselors. So, we had about 40-50 professionals in-house when SAMHSA called.

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CMT: We also had a press conference with the Mayor of Washington, DC, on the same day. The Mayor organized the event with us to give out awards and to talk about how addiction counselors were helping Washington, DC. It was very fortuitous that it happened on that day so we could get the word out. We need people to recognize that this is such a distinct, specific set of skills, knowledge, and competencies. It's not just a matter of being a social worker or a mental health worker. I am a social worker myself, and I've worked mental health. But if you don't have this set of skills, you won't get through it.

SBM: The conversations we had with SAMHSA and the Addiction Technology Transfer Center staff helped to direct their consultants to us. Also, because of us validating skills and knowledge in our own testing and certification process, they knew we would be able to send professionals with the necessary competencies. We have faith-based counselors, art therapists, adolescent counselors, nurses, and others. We were able to provide all of the skill sets they needed.

CMT: We are fortunate to have the full gamut of professionals who specialize in addiction. We have not ended that process because we know the recovery in the gulf region is going to be a long-term process.

SBM: We have had counselors go to New Orleans and Biloxi, MS. Because they are required to keep journals, we sent out a call for information to our counselors so that we have a historical perspective. That way we will be able to track their efforts, locations, and where they see a need. We can then alert the counselors who return to the field and say, "Although there may not be a treatment site here, this is where we know there is still a lot of need." There is a young lady, Samantha Hope-Atkins, who is a New Orleans resident. After Katrina, she got the first telephone hotline in New Orleans going. So, we stayed in touch with her, sending her information, pamphlets, and some supplies. We sent her names of four individuals who took sabbaticals from their jobs. She has connected with them, and they are now helping her do volunteer work for a year.

SAMHSA DTAC: What is the average length of stay?

SBM: Two weeks.

CMT: Our understanding is that they are still taking people from our list. I signed up to go in April, so I'm waiting to see if I've been chosen. I'd like to give that perspective back to our counselors as well.

SAMHSA DTAC: This really is a long-term project.

SBM: Initially they said it was going to end in November 2005. I couldn't see it then because of what we were hearing from people in the affected areas. I don't think it's going to end anytime soon because treatment facilities are still not fully running. The ones that are, are not at capacity. Some don't have the space because they are in temporary quarters. There are not enough counselors, space, and accessibility. So at least the temporary quarters that are being provided by SAMHSA for this project are giving people, who would not have had the opportunity elsewhere, the help that they absolutely need.

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The groups that are being sent usually have a physician or psychiatrist, nurse, mental health or social worker, and one or two addiction counselors. I don't know if they could do this any other way.

SAMHSA DTAC: What have you been hearing from your members about their experiences working in the gulf region?

SBM: One young lady was on the evacuee cruise ship where the residents of New Orleans were being housed. She was placed there as a crisis counselor and was supposed to be available 7 a.m.–4 p.m., but she was working day and night. She was able to address not only addiction needs but also posttraumatic stress disorder (PTSD) because she was trained in it. She performed as a great crisis counselor. But she came back refreshed because she felt she was able to give back. Another young lady stayed in one of the hotels in Biloxi, where the lights didn't stay on and the water didn't run consistently. But she was prepared because we gave them a good list of supplies. She was in the hotel with residents of Biloxi who didn't necessarily have addiction issues, but were affected by PTSD and other problems. So, she ended up working at a psychiatric treatment facility during the day and coming back to the hotel lobby with the families at night. She's an adolescent counselor, so she created a lot of games with the kids when the lights went out. She did things with the families that they could do together. I heard nothing negative at all. Although they did not have the most comfortable places to stay, they were close to the people who needed the help. They felt as though they were able to give. Every counselor I heard from called to say thank you.

CMT: I talked to some of the counselors who were personally involved in the devastation. One of the things that come to mind about that is it is really important that we serve those addiction professionals who were personally devastated. We can't expect people to give help to others when they are personally traumatized. Sometimes part of the teams have to not only support the general population, but also support the helping professionals get back on their feet. Part of the support we've been able to give some of our members is supporting them through their own process, so that they can get on their feet and go back out and help.

SBM: We've also been able to assist three counselors who relocated out of the Louisiana area. They needed assistance acquiring the credentials in the States to which they moved. We gave them membership for the year and sent them materials to study for testing in the States in which they need to be certified. We are still in contact with two of them who lost all of their documents. Since we know the trainers, we are helping them with new documents.

We tend to get the phone call from the family who is in crisis, or the school district in crisis, or the hospital nurse who has someone in their emergency room detoxing in front of them. So we really have been crisis responders during the past 30 years....

SAMHSA DTAC: The substance abuse field has not traditionally viewed itself as crisis responders. Is this changing? What role do addiction professionals have in responding to large-scale disasters?

CMT: That question is very interesting because even though we haven't traditionally been seen as crisis responders, we have been crisis responders. We tend to get the phone call from the family who is in crisis, or the school district in crisis, or the hospital nurse who has someone in their emergency room detoxing in front of

them. So we really have been crisis responders during the past 30 years in the addiction profession, even though we haven't been seen that way. I think what's changing is that people are "getting it." These are the people who know how to deal with crisis and don't get scared around crisis. We see people at their worst, when they are falling out, when they are detoxing, or when they are angry and belligerent. We know that PTSD doesn't happen in the first month, that we will be seeing a lot of it 6 months out. So we accept those relationships, give them some immediate support and some ideas about continuing support and continuing care, and do that in a way that is helpful to that person and that community.

SAMHSA DTAC: Many organizations continue to be involved in the 2005 hurricane response efforts. In what ways has NAADAC collaborated with SAMHSA and other groups?

CMT: We collaborated by putting together a cadre of professionals who were ready to go. Shirley made sure they were certified, had malpractice insurance, were medically safe, and equipped to go. That list continues today. We also worked with SAMHSA on a Webcast on trauma. Dr. Westley Clark (Center for Substance Abuse Treatment [CSAT]), Ivette Torres (CSAT), and I did a video on trauma and did a mock interview with Anne Herron (CSAT) on how to do an initial, brief risk intervention. We are hoping to use that as a training tool to help others recognize what to do in disasters, act as first responders, and do that initial interview. We are available in any way to continue to support SAMHSA. We also did an article in our newsletter on dealing with trauma and about this effort. NAADAC is there for the long term to continue to work with SAMHSA and other groups. We were also in contact with Jody Biscoe at Northwestern State University. He started the addiction studies program there. He told us how many students in the addiction studies program lost everything due to Katrina. When we were told the students could use help, we sent large shipments of clothing to them. We were also able to help with some financial support.

SBM: We are connecting with Florida as well. We've offered information packets to counselors who have not been called for this project, but are still willing to do volunteer work. Some of them have stated that they would go to Florida or to Texas. There is still a great need there. Others have volunteered as mentors for the counselors who have moved into the affected areas. Every day we get a question, either from a member or a person in need. So we can connect people that way. There are still a lot of volunteers willing to help. People have not put this behind them yet. This is one disaster in the United States, I believe, where the hands-reaching-hands sort of thing continues. Every day we get a call from someone asking how they can help.

CMT: NAADAC started a program called Members Helping Members, so people could donate to people in the affected areas. We know that they need support for their certifications, funding to get their certificate, or to go to trainings so that they can keep their certifications. There are things we can do to support them in their professional lives so that they have less stress. It's important to know that addiction professionals care about each other. Even though they make low incomes, they are willing to give. We've received donations up to $500 to help support our counselors.

SAMHSA DTAC: Is the Members Helping Members program nationwide, or is it focused on those affected by the hurricanes?

CMT: It is nationwide through NAADAC. Right now, people can designate whether they give to hurricane-affected people or generally.

SAMHSA DTAC: What sense do you have about the incidence of substance use or abuse among those affected by the 2005 hurricanes?

CMT: We know from past disasters that when a disaster hits an area, the incidence of alcohol and drug abuse and addiction increases. After New York City experienced the 9/11/2001

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terrorist attacks, the incidence of alcohol abuse increased. Based on history, you can imagine that it will be more than 20 percent of the population. Even at a conservative level, that is still huge. The general population is 8–10 percent addicted anyway, and New Orleans was already above that. And we are not even talking about the impact on the children. Children are impacted by their parents' drug and alcohol use. When you think about the impact on the children and others, I think the significance is huge. What is more important is what we do about that long term. When you look at the significance of this, you really need to look at a community strategy that is connected from the individual, to the family, to the community. That is how you can build strength back into a community that is affected not only by drug and alcohol issues and co-occurring issues, but also by the disaster issues. It is very important that we remember that come next Christmas, there will still be many people who are trying to stabilize.

SAMHSA DTAC: Many Hurricane Katrina evacuees who are methadone patients had to seek treatment far from their home methadone clinics. What is NAADAC's recommendation on guest methadone dosing?

SBM: I managed a methadone program for 29 years, so we are very familiar with guest dosing, especially in hardship situations. It is always a concern to validate identity, dosage, and program connection. In some cases, regulations allow for giving a labeled vial to a client, the lower dosage allowed by law, for a couple of days. The issue is what to do for the long term. Do you register that person in the program so that he or she is no longer a guest doser? In the case of Hurricane Katrina, my thought is that you need to register the person in the program, because most of those programs were destroyed. And if they are standing, the counselors, physicians, or dispensing nurses may have been affected and are not able to return. So, after a few days, it need not be considered a guest dosing situation. So, register the individual, and if they can't take them on, then find slots in another program. Even if it is only for 6 months, they can be offered 6 months of care. Physicians can keep that person in a stable environment with access to counseling as they reestablish themselves. If they don't have the stability of a program to return to, then they need to have access to a program for a period of at least 6 months, until it can be determined what is happening in their home State.

CMT: In a situation like this where many of the clinics have been destroyed, it may be a good idea to set up dispensing vans or dispensing support groups to help after a disaster. It's not just a matter of medication, but having the support to stay in recovery.

SBM: One of the things we were most disturbed by was that at some of the shelters, they were not allowed to have self-help meetings. These are safety nets for these individuals. If they can organize a self-help meeting under those circumstances and are not allowed to do so, it can make them question their impetus for recovery. A lot of the confusion that occurred at some shelters occurred because people did not have access to their medications and shelter workers said they couldn't trust what dosage they were on. They could be given the smallest therapeutic dosage, at least 30–40 milligrams. That is what the teams that came through from SAMHSA have done. They had physicians or psychiatrists so they could get people back on their medications and keep records for the next team.

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It is interesting that when the disaster first occurred and the American Red Cross got involved, they were not asking for addiction professionals. In fact, we were barred. They didn't understand our role. It took some work at the national level to get that lifted. NAADAC was involved with that.

SAMHSA DTAC: You spoke of the role of addiction counselors in this disaster. What is the long-term role for addiction professionals in the recovery of the gulf region? How will NAADAC continue to be involved?

SBM: We are still taking applications, asking them to get their physical, and helping them if they don't have the money for malpractice insurance. We want to be prepared. We know we will be getting another call, so we have told people that we will hold their applications, and to check in with us once a month to see if they are needed.

CMT: It is interesting that when the disaster first occurred and the American Red Cross got involved, they were not asking for addiction professionals. In fact, we were barred. They didn't understand our role. It took some work at the national level to get that lifted. NAADAC was involved with that. Some thought that we were just people in recovery. Some are in recovery, and some are not. Competency, knowledge, and training in this profession are the issue. It was very interesting to me that stereotypes still affect the addiction profession.

SBM: We are the support to the counselors who lend a lifeline to the clients. But when it comes to the clients, we want to help, too. We had a call from someone at the Superdome who found our 800 number, called from a payphone, and said they were not allowed to have meetings. You could hear the people yelling in the background, "They won't let us have our meetings."

CMT: Our job is not to advocate just for the addiction profession, but also for the clients and families who are affected by this disease. Our tag line is "We help people recover their lives." We do that through the addiction professionals, but sometimes through the clients themselves.

For more information, contact NAADAC, The Association for Addiction Professionals, 901 N. Washington Street, Suite 600, Alexandria, VA 22314; phone (703) 741-7686 or 800-548-0497; fax (703) 741-7698 or 800-377-1136; e-mail naadac@naadac.org.

NAADAC in the Gulf

SAMHSA asked all of those who were deployed to help in the gulf coast region following Hurricane Katrina to keep a journal. NAADAC plans to collect the journals of their counselors and other volunteers, with the ultimate goal of producing a book containing stories of their experiences. Any funds raised through book sales will be donated to ongoing efforts to assist counselors in and from the gulf coast region. NAADAC would appreciate donations of any volunteer's journal in any format (electronic, handwritten, or photocopied), along with a personal photo, any photos from the region, poetry, artistic renderings, lyrics, or anything else created during the deployment. The following is an excerpt from one NAADAC counselor's deployment journal.

My first deployment in October was to Houma, LA, where I worked at a shelter in the gymnasium at Nichols College in nearby Thibodaux, LA. Expecting to be providing substance abuse counseling, I found myself working closely with FEMA, the American Red Cross, and other agencies helping evacuees sign up for FEMA assistance and then obtain semi-permanent housing in trailers. I soon realized that the people in the shelter, evacuated from their homes and the comfort of community, were in the throes of what I began to refer to as DCD-denial, courage, and denial. They were in denial about the severity of the storm, had the courage to make it through, and then returned immediately to denial about the reality of what had occurred. It also became clear that shelter residents had little trust in what the authorities were reporting.

We took evacuees into New Orleans in an attempt to help them understand that it would be a long time, if ever, before they could return to their homes. As a SAMHSA worker, I went along to provide support for those going back for the first time to see the wreckage Katrina had wrought and to see what remained of their former lives. We traveled in convoy style into the Ninth Ward, home to most of the shelter residents, with a sheriff's escort because the area had not yet been secured. There was a palpable air of lawlessness that hung over the vacant

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streets and piles of rubble. I watched people again and again, leave Thibodaux with a sense of hope, enter their homes with boxes to collect belongings, and emerge with a few scraps of paper and a stray item or two, if even that. The sadness in their eyes as we returned was haunting, but it was only after they had returned from one of these trips that they would even look at the trailers that were being offered to them, much less consider living in one.

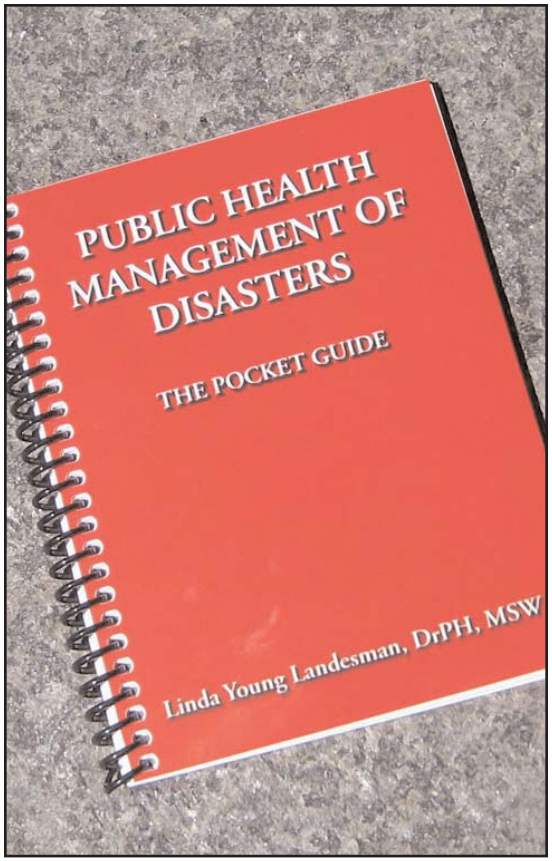
As I look back on the counseling I provided, some of the things that stand out happened where I least expected to be of use. One night I went to the laundry room and soon found myself holding a woman while she cried for half an hour. She told me she would never have sought us out and was not about to burden anyone else on the ship with her problems. On another occasion I found myself counseling our waitress at K-Pauls over dessert; she was thankful she had finally found a situation in which she could talk about her losses.

All of my assignments were different, but in a sense they were all the same. In Thailand they have a saying "Same same, but different." I cannot think of a more accurate way to describe my experience. I didn't really know what to expect on any of my four deployments. I boarded the plane in San Francisco each time with little more than the suggestion that SAMHSA provided me: Be flexible. It was the best advice I could have received. I never knew for sure when I would find myself of use, but was determined to always stay in the moment.

After realizing that it is impossible to help everyone, I decided to simply help the people I could, and as many of them as I came across. I am a better person because of these experiences.

This journal excerpt was contributed by Connie Millimaki, co-founder of Alternatives, a California community-based treatment provider. She also runs Woman Alive, a female anger management program in Napa County. She has made four trips into Louisiana and Mississippi, providing disaster assistance through SAMSHA. She can be contacted by e-mail at cmillimaki@scglobal.net or by phone at (707) 255-1940.

Book Review



Linda Young Landesman, Dr.P.H., M.S.W. (2006). *Public Health Management of Disasters: The Pocket Guide*. Washington, DC: American Public Health Association.
ISBN: 0-87553-069-9

PUBLIC HEALTH MANAGEMENT OF DISASTERS: THE POCKET GUIDE

Public Health Management of Disasters: The Pocket Guide was developed for public health professionals at the local, State, and Federal levels to serve as a reference for essential information. Linda Young Landesman, Dr.P.H., M.S.W., developed this guide to be a quick source of information drawn from her previously published book titled *Public Health Management of Disasters: The Practice Guide*. It provides information about public health interventions to be used preceding and immediately following a disaster. This publication is designed to be used as a field guide, so information is laid out in a clear and concise manner. It provides quick access to necessary information concerning preparation, disasters, diseases, mental health, food safety, and data collection.

It begins with an informative overview that describes responsibilities of entities involved in the public health response to disasters and explains how they coordinate with one another to deliver services. The overview also covers the use of disaster plans, epidemiology, and information systems in planning for and studying disasters, as well as how Incident Command Centers organize activities and how State governments can obtain Federal assistance.

The first chapter of the pocket guide describes the specific tasks that must be carried out when it is clear that a disaster is imminent. The second chapter provides pre- and post-impact strategies for 13 different types of disasters. The strategies are tailored to each disaster's specific characteristics and threats. The third chapter deals with diseases. The table on page 59, "Diseases Affecting Displaced Persons in Disasters," is particularly useful. It calls out a number of diseases commonly seen in disaster victims and details the symptoms, risk factors, and public health hazards associated with them.

A short section on mental health follows. It lists the community behavioral services needed following a disaster, provides information on setting up family assistance centers, and points out that in some instances, supplemental mental health personnel are deployed to the site of a disaster.

A practical chapter on food safety identifies diseases that can be caused by food. The symptoms associated with the foods are listed, as well as the foods that typically cause them and the

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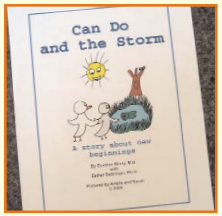
prevention or control techniques that should be used. The final chapter on data collection informs the reader what information should be collected during the course of disaster response.

This pocket guide is a convenient source for essential information concerning disaster public health. It is useful to those in the disaster mental health field who would like to be informed on all public health issues surrounding a disaster. The appendix contains additional information. The list of common disaster-related acronyms found here will certainly come in handy. The portable size of this guide makes it easy to bring as a reference, if deployed. The information included may be of particular use during times of disaster when electronic resources, such as the Internet, are not readily available.

If you would like more detailed information on the topics covered, refer to *Public Health Management of Disasters: The Practice Guide*, second edition, by Dr. Linda Young Landesman. Both the *Pocket Guide* and the full *Practice Guide* may be ordered from the American Public Health Association (APHA). If you would like to place an order, call toll-free 888-320-APHA; fax 888-361-APHA; e-mail apha@bpd.com; or visit APHA's Web site http://www.apha.org/media. The publication is 107 pages, and the cost is $32 (or $22 for APHA members) plus shipping and handling.

Recommended Reading

CAN DO AND THE STORM: A STORY ABOUT NEW BEGINNINGS



Can Do and the Storm: A Story about New Beginnings is a reassuring story about animals who make it through a storm. This book was written to help children who have been affected by hurricanes. It was written by "Ducktor Morty, M.D." (aka. Morton D. Sosland, M.D.), a child psychiatrist, with help from Ester Deblinger, Ph.D., a child psychologist and member of the National Child Traumatic Stress Network.

A duck named Can Do is the main character in this story about a community of animals who experience a hurricane. The story uses endearing animals to cover the often traumatic events that are experienced during and following a natural disaster. The story depicts a range of possible hardships, such as evacuation, being separated from family and friends, living in a shelter, and dealing with the physical damage caused by a storm. It also explores topics with which recent hurricane survivors have had to deal, such as the process of rebuilding a community, leaving a community, making a home in a new area, or returning home when others do not. Presenting these upsetting issues to children is made less difficult through the rhyming story and color-in illustrations that make up this book. It will be comforting for children to see the characters overcome some of the same problems that they are currently facing.

Not only does this book provide an entertaining story for a child, but it also gives parents/caregivers, teachers, and therapists an opportunity to begin talking, in a non-threatening way, about the feelings a child is experiencing. In the introduction to this story, sample questions are given to assist adults in beginning such a dialogue. One question asks, "How do you think the ducks felt during the storm?" Talking about an experience in an abstract way such as this allows children to feel more comfortable talking about their own feelings and experiences. This book will help build a sense of hope in children who have faced hurricanes and will hopefully be a fun and beneficial way for kids to think about, talk about, and grow from their experiences.

Can Do and the Storm: A Story about New Beginnings is available free online at: http://www.thecandoduck.com.



Upcoming Meetings

THE 14TH ANNUAL NATIONAL VOLUNTARY ORGANIZATIONS ACTIVE IN DISASTERS CONFERENCE

MAY 9–12, 2006
RALEIGH, NC

This conference includes National Voluntary Organizations Active in Disasters (NVOAD) committee meetings, as well as opportunities to exchange ideas on disaster response and training workshops. For more information, contact Ande Miller, NVOAD, amiller@nvoad.org, http://www.nvoad.org/annualconf1.php.

THE 30TH ANNUAL CONVENING OF CRISIS INTERVENTION PERSONNEL

MAY 12–14, 2006
CHICAGO

This conference addresses all areas of crisis intervention (from disaster relief after major natural or manmade catastrophes to working with victims of domestic violence) and welcomes both professionals and volunteers in the field as presenters and attendees. The conference is sponsored by CONVENING, the In Touch Hotline of the University of Illinois Chicago, CONTACT USA, and the Illinois Department of Human Services. In addition to the 42 formal presentations, there is ample opportunity for informal networking and exchange of information. For more information, go to http://www.uic.edu/orgs/convening.

THE SPIRIT OF RECOVERY: ALL-HAZARDS BEHAVIORAL HEALTH PREPAREDNESS AND RESPONSE-BUILDING ON THE LESSONS OF HURRICANES KATRINA, RITA, AND WILMA

MAY 22–24, 2006
NEW ORLEANS

During the past year, the United States has experienced an unprecedented number of disasters, including the hurricanes that devastated the gulf coast States, school shootings, and suicide clusters. SAMHSA continues to emphasize the importance of all-hazards disaster behavioral health preparedness, and is convening this national summit as a followup to previously held trainings to involve States, Territories, and the District of Columbia in the planning process. This meeting will allow States and Territories to assess the progress made on disaster behavioral health plans and help address existing barriers and needs. Participants will interact in a peer-to-peer environment to review lessons learned from Hurricanes Katrina, Rita, and Wilma; identify opportunities for consolidation of the ongoing response to behavioral health issues resulting from the 2005 hurricanes; and strategize all-hazards preparedness efforts for the future. For more information, go to http://www.spiritofrecoverysummit.com.

THE FIFTH UNIVERSITY OF CALIFORNIA AT LOS ANGELES (UCLA) CONFERENCE ON PUBLIC HEALTH AND DISASTERS

MAY 21–24, 2006
LONG BEACH, CA

This conference is designed for public health professionals, as well as individuals and organizations, from both the public and private sectors involved in emergency public health preparedness and response. The diverse topics

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will be relevant to public health and medical practitioners, emergency medical services professionals, researchers, and managers involved in the wide range of emergency public health issues resulting from natural and manmade disasters. For more information, contact the UCLA Center for Public Health and Disasters at cphdr@ucla.edu, http://www.cphd.ucla.edu/conferenceframe.htm.

THE 17TH ANNUAL INTERNATIONAL TRAUMA CONFERENCE—PSYCHOLOGICAL TRAUMA: NEUROSCIENCE, ATTACHMENT, AND THERAPEUTIC INTERVENTIONS

JUNE 15–17, 2006
BOSTON

The objective of this course is to present current research findings about how people's brains, minds, and bodies respond to traumatic experiences, and the role of relationships in protecting and restoring safety and regulation. We will explore posttraumatic responses at different developmental levels, and the treatment implications of these findings. The course will examine the cutting edge of treatment interventions for various trauma-based symptoms. For more information, go to http://www.themeadows.org.

THE AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION ANNUAL LEADERSHIP TRAINING AND CONFERENCE

JULY 20–22, 2006
ST. LOUIS, MO

For more information, go to http://www.amhca.org.

THE AMERICAN PSYCHOLOGICAL ASSOCIATION 2006 ANNUAL CONVENTION

AUGUST 10–13, 2006
NEW ORLEANS

For more information, go to http://www.apa.org/convention06.

THE UNIVERSITY OF SOUTH DAKOTA DISASTER MENTAL HEALTH INSTITUTE—INNOVATIONS IN DISASTER PSYCHOLOGY 2006: CULTURALLY RESPONSIVE DISASTER MENTAL HEALTH

SEPTEMBER 7–9, 2006
BLACK HILLS, SD

Two recent catastrophic events have highlighted the critical importance of cultural responsibility in providing psychological support following disasters. In the preparation for and response to Hurricane Katrina, cultural issues played an enormous role. Similarly, cultural aspects of the response to the December 26, 2004, tsunami have been an important issue. This conference is intended for disaster mental health professionals, and health and mental health professionals nationally and internationally. The overall objective is for the participants to learn more about cultural responsiveness and sensitivity in disaster psychology. For more information, go to http://www.usd.edu/dmhi/conference.cfm.

CALL FOR INFORMATION

The Dialogue **is an arena for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. Readers are invited to contribute profiles of successful programs, book reviews, highlights of State and regional trainings, and other news items. If you are interested in submitting information, please contact Kathleen Wood at kathleenw@esi-dc.com.**